North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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Michael F. Easley, Governor
Carmen Hooker Odom, Secretary
Michael Moseley, Director

May 21, 2004

MEMORANDUM

To: Legislative Oversight Committee Members
MH/DD/SAS Commission
Consumer/Family Advisory Committee Chairs
Advocacy Organizations and Groups
North Carolina Association of County Commissioners
County Managers
County Manager Chairs
North Carolina Council of Community Programs
State Facility Directors
Area Program Directors
Area Program Board Chairs
Provider Organizations
MH/DD/SAS Professional Organizations and Groups
MH/DD/SAS Stakeholder Organizations and Groups
Other MH/DD/SAS Stakeholders

From: Mike Moseley
Re: Communication Bulletin #019
DRAFT State Plan 2004

Attached is a draft copy of State Plan 2004. This plan reflects the continued evolution of our reform efforts and builds on State Plan 2001: Blueprint for Change. The information contained in the Plan reflects the work that has been accomplished and outlines key developments that must occur over the next fiscal year in order to continue to move reform forward.

Please review and offer comments on this draft. We will be accepting comments through the close of the business day on June 21, 2004. Comments may be e-mailed to Steven Hairston at Steven.Hairston@ncmail.net or mailed to him at 3003 Mail Services Center,

Raleigh, North Carolina 27699-3003. In order for comments sent by mail to be considered for inclusion in the final document, they must be received by the close of the business day on June 21, 2004.

The final State Plan 2004: Blueprint for Change will be published by July 1, 2004. Thank you for your continued leadership in the reform efforts.

cc: Carmen Hooker Odom
Lanier Cansler
James Bernstein
DHHS Division Directors
DMH/DD/SAS Executive Leadership Team
Rob Lamme
Jim Klingler
Dick Oliver
Kaye Holder
Wayne Williams
Richard Slipsky
DMH/DD/SAS Staff

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Executive Summary

State Plan 2004: Blueprint for Change provides information for the citizens of North Carolina on the continuing efforts to reform North Carolina's public mental health, developmental disabilities and substance abuse (mh/dd/sa) services system. This is the third annual revision of the plan. The State Plan's main philosophy and goals remain the same.

In response to Session Law 2001-437, *State Plan 2001* established an understanding of reform including focusing the state's limited resources on those who are the most severely disabled. *State Plan 2002* outlined the key policy issues that set the direction for reform and *State Plan 2003* refined policy issues and set a course for developing some of the products and processes necessary to continue the momentum. *State Plan 2004* provides details on the key tasks and issues that will be addressed during state fiscal year 2004-2005 in order to continue the process of system transition.

The Citizens We Serve

Providing services to individuals with the most severe disabilities is the primary focus of the re-designed mh/dd/sa system. As legislatively mandated, the Department has established "target populations" that meet specified criteria including diagnostic, functional and the circumstances unique to each individual. The target populations for adult mental health, child mental health, developmental disabilities and substance abuse have not changed from prior versions of the State Plan.

However, it is important to note that:

- Any citizen can seek services through the public mh/dd/sa system. If the person is not a member of a target population, the system will provide screening, triage and referral to private providers.
- Any citizen who is eligible for Medicaid and meets "medical necessity" for covered mh/dd/sa services is entitled to those services, supports, treatment and/or care. If the person is not a member of a target population, the system will typically provide services that are less intensive and shorter in duration. If the person is a member of a target population, the system will usually provide services, supports, treatment and/or care that are more comprehensive, intensive and of longer duration.
- Any citizen who is part of a target population can receive services through the public mh/dd/sa system. However, if not eligible for Medicaid, the provision of services is not an entitlement. Thus, the publicly sponsored system is challenged with managing available resources to meet the needs of these priority populations.

Organizational Structure of the Public MH/DD/SAS System

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) remains actively involved in reform. The members of this committee meet regularly with leadership of the Department of Health and Human Services (DHHS), its Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the public to receive input on the status of the reform efforts. The Division provides quarterly reports to the LOC on matters related to implementation.

The North Carolina Commission for MH/DD/SAS, which was created by the General Assembly, advises the Secretary of the Department about the need for, provision and coordination of services. The Commission has authority to make rules based on statutes regarding operations of local mh/dd/sa program operation and state facilities; licensing of mh/dd/sa facilities; controlled substances; clients' rights; human rights committees; and mh/dd services for people in the custody of the Department of Correction.

The Division of MH/DD/SAS has completed a reorganization that is designed to implement the State Plan and promote and accommodate the reformed system statewide. The Division's central administration consists of the Director's Office and five sections organized along functional lines. These sections are:

- State Operated Services – This section holds a dual role as manager and provider of state operated services and facilities and is held to the same quality and best practice standards as are local management entities (LMEs). The Division's state facilities consist of four regional psychiatric hospitals, four developmental disabilities centers, three substance abuse treatment centers, a specialty nursing facility for mentally ill consumers, a specialty nursing facility for consumers with developmental disabilities and two residential facilities for children with emotional disturbances.

- Community Policy Management – This section is responsible for leadership, guidance and oversight of the community based service delivery system. They collaborate with a wide variety of public and private partners to promote recovery through the reduction of stigma and barriers to services. In addition, this section performs the functions of the single state agency (SSA) for substance abuse and of the state methadone authority. The section is organized into the following teams: the Quality Management Team, the Best Practice and Community Innovations Team, the Local Managing Entity Systems Performance Team, the Justice System Innovations Team, the Prevention and Early Intervention Team and the Employee Assistance Program Team.

- Advocacy and Customer Services – This section leads the Division's efforts to create a community where people with disabilities are valued and treated with dignity and where stigma, accompanying attitudes, discrimination and other barriers to recovery are eliminated. The State Facilities Advocates Team ensures the rights of consumers at state facilities. The Customer Services and Community Rights System Team ensures the rights of consumers served in the community, oversees

response to complaints and monitors community customer services. The Consumer Empowerment Team ensures consumer and advocacy voice in Division reform efforts and provides technical assistance to local consumer and family advisory committees (CFACs), to local consumer controlled advocacy organizations and to self-advocacy initiatives.

- Resource/Regulatory Management – This section is responsible for supporting the efforts and ensuring accountability of the other sections of the Division. This is accomplished through the work of the Budget and Finance Team, the Information Systems Team, the Accountability Team, the Regulatory Team and the Contract Management and Development Team.

- Administrative Support – This section is responsible for providing support and ensuring coordination with DHHS for operations components of the Division. This section is composed of three teams: the Planning Team, the Division Affairs Team and the Communications and Training Team.

Community based mental health, developmental disabilities and substance abuse services are provided through a network of 33 area/county programs, which cover the state's 100 counties. These area/county programs are in the process of making the transition from providing mh/dd/sa services to becoming local management entities (LMEs) that oversee and manage local services. As separate local governmental entities (with three exceptions), the local programs are governed by boards appointed by their respective boards of county commissioners. Statutorily, these boards are responsible for, among other things, planning, budgeting, implementing and monitoring community based mental health, developmental disabilities and substance abuse services.

Progress of Reform to Date

Over the past three years, the Division has been developing the infrastructure needed to enact reform, including what is necessary to build community capacity and reduce unnecessary institutionalization according to the state's *Olmstead Plan*.

Status of the Community System

The reform legislation called for a phased approach by which area programs become certified as LMEs. Thirteen area programs chose to participate in Phase I that began July 2003, three area programs chose Phase II that began January 2004 and fifteen area programs chose Phase III that will begin July 2004. During fiscal year 2003-2004, all area programs were sent certification letters regarding their status as an LME and status regarding the certification of their local business plans.

Staff of the Division has been working to build an infrastructure that will enable system transition in a manner that is least disruptive to services delivery for citizens of the state. The

Division is committed to supporting and serving citizens through changes in the service definitions that reflect models of best practice and provider qualifications. **It is very important for area programs, LMEs and consumers and families to understand that services will not be divested until an area program has the adequate provider/providers in place to provide the services needed so that consumers' treatment and supports are not disrupted or discontinued.**

Status of the State Facilities

As part of the *Olmstead Plan*, the Division has established a process for assessing all qualified individuals residing in state facilities. From this assessment, both individual service planning and aggregate community capacity needs can be determined. The staffs of the Division, the state facilities and the LMEs are working to develop community capacity to provide the services and supports that are needed by those returning to the community.

A number of steps have been taken to reduce reliance on state facilities. Relevant divisions of DHHS are working to develop (1) a specialty nursing facility model for consumers whose needs exceed the capacity of existing nursing home models and (2) specialty services for elderly consumers who need a non-nursing facility congregate living setting with additional mental health care. The Mental Health Trust Fund has been accessed to facilitate the movement of consumers from state facilities to community settings and for start-up of needed services. A new state-of-the-art psychiatric hospital will be built in Butner to serve the central region of North Carolina.

Status of Departmental/Division Efforts

During the past three years, the Division has partnered with other state agencies, such as the divisions of Medical Assistance, Facility Services and Vocational Rehabilitation, with private associations such as the NC Council of Community Programs and the NC Association of County Commissioners, and with other professional and consumer organizations. An external Stakeholders Group was appointed by Secretary Carmen Hooker Odom to assist the Division with policy development. The Public Partners Policy Group was established to address issues related to reform that are of concern to directors of LMEs, county managers, county commissioners and DHHS. Finally, the Department has established the State Consumer and Family Advisory Committee (S-CFAC). This committee works with Division leadership to conduct oversight of Division operations and to accomplish strategic outcomes of the State Plan. The S-CFAC reports directly to the DHHS Secretary.

Implementation of reform requires that the Division has access to accurate and relevant information for analysis and reporting of management and financial data for planning, establishing benchmarks, measuring outcomes and decision-making. To support the work of the Division, LMEs and state facilities, the Division's information technology efforts have centered on the development of the Integrated Payment and Reporting System (IPRS), the Medicaid Management Information System (MMIS) and the Healthcare Enterprise Accounts Receivable and Tracking System (HEARTS), in addition to compliance with HIPAA requirements.

Goals and Objectives for State Fiscal Year 2004-2005

Thirty-seven key developments have been identified for SFY 2004-2005 that will enable the Division to continue to move reform forward. These key developments have been categorized into four areas. These four areas are Management and Leadership, Finance, Programmatic Issues and Administration and Contracts. Each of the four areas has an overall outcome and the specific developments that must be completed to support that outcome.

Introduction

State Plan 2004 provides information for the citizens of North Carolina on the continuing efforts to reform North Carolina's public mental health, developmental disabilities and substance abuse services system. This Plan provides a recap of reform efforts over the past three years and outlines the key developments that will occur during state fiscal year 2004-2005.

This year's State Plan is organized into four chapters.

Chapter 1: Foundations of Reform – This chapter provides the policy framework for reform. Also, it reiterates the mission, principles and vision of the Division and a description of the target populations. The term "citizen" is used in this Plan as a description of all of the residents of our state.

Chapter 2: Organizational Structure of the Public MH/DD/SAS System – This chapter provides a detailed description of the organization and structure of the public system.

Chapter 3: Progress of Reform to Date – This chapter answers the question "What have we accomplished since State Plan 2001?" It provides a status report on reform related developments affecting the community system, state facilities and the Department.

Chapter 4: Goals and Objectives for State Fiscal Year 2004-2005 – This chapter outlines the key tasks and issues to be addressed during SFY 2004-2005 to continue to move reform forward. These developments have been categorized into four areas: *management and leadership, finance, programmatic issues, and administration and contracts.*

Chapter 1. Foundations of Reform

Overview

The North Carolina General Assembly has mandated significant reform of the manner in which publicly funded mental health, developmental disabilities and substance abuse (mh/dd/sa) services are managed and delivered in the state. The primary elements of the reform are designed to ensure that public funding supports a service system that provides consumers, families and communities with necessary services and appropriate supports to facilitate community-based recovery from mental health and substance abuse disorders, and safe community-based choices that enhance the ability of individuals with developmental disabilities to exercise self-determination and achieve their maximum potential. These policy objectives are consistent with the final report from President Bush's New Freedom Commission on Mental Health, the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) system improvement objectives, and the U.S. Supreme Court's Olmstead decision.

State Plan 2001: Blueprint for Change initiated the first major reform of North Carolina's mental health, developmental disabilities and substance abuse services system in more than thirty years. The State Plan was developed in response to the passage of Session Law 2001-437. The Session Law called for sweeping reforms in the service delivery system over a five-year period. *State Plan 2001* centered on establishing an understanding of reform to include focusing the state's limited resources on those who are the most severely disabled.

State Plan 2002 continued the central themes of *State Plan 2001*. In addition, the Plan outlined the key policy issues that would set the direction for reform.

State Plan 2003 provided further refinement of the policy issues and established a course for developing some of the products and processes necessary to continue the momentum for reform.

State Plan 2004 is in the same vein as *State Plan 2003* in that it provides details on key tasks and issues that must be addressed in order to continue the process of "system transition."

Mission, Principles and Vision

The mission, principles and vision of the State Plan guide and inform North Carolina's reform effort through the great changes ahead and tell us when we have achieved success. The road may be long, and change is hard, but the goal we are striving for is worth all the effort.

Mission

North Carolina will provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice.

Guiding Principles

- Treatment, services and supports to individuals and their families shall be appropriate to needs, accessible and timely, consumer-driven, outcome oriented, culturally and age appropriate, built on individual strengths, cost effective and reflect best practices.
- Research, education and prevention programs lower the prevalence of mental illness, developmental disabilities and substance abuse; reduce the impact or stigma; and lead to earlier intervention and improved treatment.
- Services should be provided in the most integrated community setting suitable to the needs and preferences of the individual planned in partnership with the individual and/or family.
- Individuals should receive the services needed based on a person-centered plan and in consideration of any legal restrictions, varying levels of disability, and fair and equitable distribution of system resources.
- System professionals will work with individuals and their families to help them get the most from services.
- Services shall meet measurable standards of safety, quality and clinical effectiveness at all level of the mental health, developmental disabilities and substance abuse system and shall demonstrate a dedication to excellence through adoption of a program for continuous quality improvement.
- All components of the mental health, developmental disability and substance abuse system shall operate efficiently.

Vision

- Public and social policy towards people with disabilities will be respectful, fair and recognize the need to assist all that need help.
- The state's service system for persons with mental illness, developmental disabilities and substance abuse problems will have adequate, stable funding.
- System elements will be seamless; consumers, families, policy makers, advocates and qualified providers will unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.
- All human service agencies that serve people with mental health, developmental disabilities and substance abuse problems will work together to enable consumers to live successfully in their communities.

<u>Consumers will have:</u>

- Meaningful input into the design and planning of the service system.

- Information about services, how to access them and how to voice complaints.
- Opportunities for employment in the system.
- Easy, immediate access to appropriate services.
- Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life.
- Safe and humane living conditions in communities of their choice.
- Reduced involvement with the justice system.
- Services that prevent and resolve crises.
- Opportunities to participate in community life, to pursue relationship with others and to make choices that enhance their productivity, well being and quality of life.
- Satisfaction with the quality and quantity of services.
- Access to an orderly, fair and timely system of arbitration an resolution.

Providers and managers will have:

- Opportunity to participate in the development of a state system that clearly identifies target groups, core functions and essential service components.
- Access to an orderly, fair and timely system of arbitration and resolution.
- Documentation and reimbursement systems that are clear, that accurately estimate costs associated with services and outcomes provided and that contain only these elements necessary to substantiate specific outcomes required.
- Training in services that are proven.

The Citizens We Serve

Providing services to individuals with the most severe disabilities is the primary focus of the re-designed system. As legislatively directed, the Department established criteria to identify individuals with various disabilities. The criteria include not only diagnostic[1] and functional elements but also circumstances unique to each individual such as availability and access to appropriate services that meet the needs of each person.

The populations described in this section -- the "target populations" -- represent individuals with the most severe types of disabilities. The publicly sponsored mental health, developmental disabilities and substance abuse specialty system is committed to serving these populations. However, there are several additional considerations to be made, as follows.

- Regardless if an individual is part of the target population, potentially, any citizen could seek services through the public system. The system's response to such requests could include screening, triage and referral, as key examples. For individuals not in the target

[1] Clinical diagnoses are made according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R). Classification for billing purposes is made according to the International Classification of Diseases (ICD-9).

population who have the personal resources (insurance and ability to pay), the system's response could also include linking those persons to private providers for longer term services -- post crisis individual therapy, as an example.

- Medicaid beneficiaries who have a condition that meets medical necessity for particular covered services are entitled to those services. These individuals are entitled to receive the supports, services, treatment and/or care regardless of whether they are identified as part of the state defined target populations. Medicaid beneficiaries who are not part of the state defined target populations, typically, require independent practitioner types of services that are less intensive and shorter term in duration. Medicaid beneficiaries who are included in the state defined target populations, generally, require supports, services, treatment and/or care that are more comprehensive, intensive and of longer duration.

- Individuals who are part of the state defined target populations who are not Medicaid eligible will be served by the publicly sponsored specialty system. However, the provision of services to these individuals is not an entitlement as in the case of Medicaid beneficiaries. Thus, the publicly sponsored specialty system is challenged with managing its available resources to best meet the needs of these priority populations.

The State Plan for system reform adopts a cross-disability approach that requires response to all of the conditions that affect successful community living. Clinicians must be able to assess for co-occurring disorders, and treatment, services and supports need to be integrated across all disabilities. The target populations include the following.

Adult Mental Health

According to estimates by the federal Center for Mental Health Services, during a 12-month period, approximately 5.4 percent of the adult population have a serious mental illness. This means that in North Carolina, during a 12-month period, approximately 322,000 adults have a diagnosable mental, emotional or behavioral disorder that has resulted in functional impairment that substantially interferes with or limits one or more major life activity. Within this population, approximately 99,000 have severe and persistent mental illnesses (SPMI) that interfere substantially with their ability to manage the demands of daily living.

Mental illnesses are disorders characterized by disturbances in a person's thoughts, emotions or behavior. The term "mental illness" can refer to a wide variety of disorders, ranging from those that cause mild distress to those that severely impair a person's ability to function.

The resources of the adult public mental health delivery system are targeted to adults with severe and serious mental illnesses. Within the resources available, the system will provide, at a minimum, a base level of service to all persons in the target population who seek services or who can be engaged through outreach activities. Additionally, priorities are established within target populations to guide the development and provision of specialty services and programs to people with the most significant disabilities. Recent advances in treatment for individuals with serious mental illness (SMI) and severe and persistent mental

illness (SPMI) make it possible for individuals with these conditions to live far more satisfying lives than ever before. The system for adults with SPMI and SMI adopts a rehabilitation and recovery approach focusing on providing or assisting individuals to obtain and maintain the skills they need to live as normally as possible in communities of their choice.

Adult Mental Health Target Populations for Community Services

Persons with severe and persistent mental illness (AMSPM)

People in this target population include adults, ages 18 and over, who meet diagnostic criteria and who as a result of a mental illness exhibit functioning that is so impaired as to interfere substantially with their capacity to remain in the community. The disability of these persons limits their functional capacities for activities of daily living such as interpersonal relations, homemaking, self-care, employment and recreation. The following diagnoses are included: schizophrenia, schizoaffective and schizophreniform disorders, bipolar disorder, major depressive disorder and psychotic disorder not otherwise specified. Functional status is assessed using the Global Assessment of Functioning (GAF).

Level of functioning criteria includes:

Any client who has or has ever had a GAF score of 40 or below.

OR

Current client who never had a GAF assessment when admitted

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 40 or below).

OR

Current client who when admitted met level of functioning criteria but as a result of effective treatment does not currently meet level of functioning criteria

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 40 or below).

OR

New client who does not currently meet GAF criteria and no previous GAF score is available and who has a history of:

- Two or more psychiatric hospitalizations.

OR

- Two or more arrests.

OR

- Homelessness.

Must be reassessed annually or with significant change in functioning.

NOTE: An individual can remain in the target population even though his/her level of functioning might improve beyond the initial GAF score of 40.

Persons with serious mental illness (AMSMI)

These are people 18 years or older who have a mental, behavioral, or emotional disorder that can be diagnosed and substantially interferes with one or more major life activities. These include delusional disorders, shared psychotic disorders, dissociative disorders, factitious disorders, obsessive-compulsive disorders, phobias, dysthymic disorder, borderline personality disorder, pedophilia, exhibitionism, anorexia, bulimia, post traumatic stress disorder, impulse control disorder and intermittent explosive disorder. Functional status is assessed using the GAF.

Adult, ages 18 and over, who meets diagnostic criteria and level of functioning criteria include:

Any client who has or has ever had a GAF score of 50 or below.

OR

Current client who never had a GAF assessment when admitted

AND

Who without ongoing treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 50 or below).

OR

Current client who when admitted met level of functioning but as a result of effective treatment does not currently meet level of functioning criteria

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 50 or below).

OR

New client who does not currently meet GAF criteria and no previous GAF score is available, and who has a history of:

- Two of more hospitalizations.

OR

- Two or more arrests.

OR

- Homelessness.

Must be reassessed annually or with significant change in functioning.

NOTE: An individual can remain in the target population even though his/her level of functioning might improve beyond the initial GAF score of 50.

Adult deaf or hard of hearing (AMDEF)

Adult, ages 18 or over, assessed as having special communication needs because of deafness or hearing loss and having a qualifying mental health diagnosis.

Adult homeless – PATH (AMPAT)

Adult, ages 18 and over, with a serious long-term mental illness or a serious long-term mental illness and substance abuse diagnosis, and is:

- Homeless, as defined by:

  (1) Lacks a fixed, regular and adequate nighttime residence.

  OR

  (2) Has a primary night-time residence that is:

    (a) Temporary shelter.

    or

    (b) Temporary residence for individuals who would otherwise be institutionalized.

    or

    (c) Place not designed/used as a regular sleeping accommodations for human beings.

OR

- At imminent risk of homelessness as defined by:

  (1) Due to be evicted or discharged from a stay of 30 days or less from a treatment facility.

  AND

  (2) Who lacks resources to obtain and/or maintain housing.

Must be reassessed annually.

Priority Populations within Target Populations (This is an all inclusive list.)

- **Persons with multiple diagnoses**: Persons 18 or older with a severe and persistent mental illness and a diagnosis of substance abuse and/or mental retardation or serious health problem including HIV disease.
- **Mentally ill adults in the criminal justice system**: Persons 18 or older with serious mental illness that are released from the Division of Prisons, or are in local jails or on probation.
- **Elderly persons**: Persons age 65 and over with a serious mental illness, including dementia.
- **Deaf mentally ill persons**: Persons 18 or older with a mental, behavioral or emotional disorder that can be diagnosed who need specialized services provided by staff who have American Sign Language skills and knowledge of deaf culture.
- **Minorities**: Adults with severe and persistent mental illness who are disproportionately represented in the system.

Adult Mental Health Target Populations for State Hospitals

In the next five years, state hospitals should revise their complement of beds and services to focus on their mission of providing psychiatric inpatient care to individuals with severe mental illness who cannot be appropriately treated in their local communities. Efforts already underway to prevent unnecessary institutionalization by directing people to local service providers whenever possible will continue.

Primary populations to be served among state hospitals

- Adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders, requiring brief acute inpatient treatment of a few days to stabilize and return to their communities.
- Adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders, requiring long-term inpatient rehabilitative treatment of approximately three to six months, to prevent or correct a rapid relapse and readmission cycle, or who remain dangerous to self or others.
- Children with severe emotional disorders requiring acute inpatient treatment to stabilize and return to a less restrictive environment.
- Older adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders requiring acute inpatient treatment to stabilize and return to their communities.
- Adults with psychiatric illness and substance abuse disorders, or serious illness such as HIV requiring acute and/or longer-term inpatient treatment to stabilize and prevent rapid relapse and readmission.

Specialty populations to be served

- Forensic patients, including those found incapable of proceeding with court trials (House Bill 95), not guilty by reason of insanity and other detainees.
- Patients taking part in a research protocol.
- Deaf consumers requiring acute or long-term inpatient psychiatric services.

Adult Mental Health Target Populations for the NC Special Care Center

The mission of the NC Special Care Center is to provide intermediate and skilled nursing care for individuals referred from state hospitals and for people who can't be served in their communities because of insufficient bed-space and insufficient psychiatric services of the intensity needed.

Primary populations to be served

- Consumers with severe mental illness requiring ICF level of nursing care (intermediate care facility).

- Consumers with severe mental illness requiring SNF level of nursing level care (skilled nursing facility).

Specialty population to be served

Consumers with mid-stage Alzheimer's disease requiring nursing care.

Child Mental Health

North Carolina conservatively estimates 10 to 12 percent of the state's children experience serious emotional disturbance (SED). This is based on the prevalence rate cited in the Federal Register, June 1998. The NC Office of State Budget and Management estimates that there are 1,964,047 children in North Carolina under age 18 based on U.S. 2000 census data. The number of children in this age group with SED is between 196,404 and 235,686.

Seriously emotionally disturbed child with out-of-home placement (CMSED)

Child, under the age of 18, with atypical development (up to age 5) or serious emotional disturbance (SED) as evidenced by the presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9.

AND

Functional impairment that seriously interferes with or limits his/her role or functioning in family, school or community activities as indicated by one or more of the following:

- CAFAS score of at least 90; **OR**
- Total CAFAS score is greater than or equal to 70 and it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning; **OR**
- In need of specialized services from more than one child-serving agency (e.g. mental health provider(s) and DSS, DPI/schools, DJJDP, DPH, DCD or health care).

AND

Placed out of the home or at risk of out-of-home placement, as evidenced by any of the following:

- Utilizing or having utilized acute crisis intervention services or intensive wraparound services in order to maintain community placement within the past year.
- Having had three or more psychiatric hospitalizations or at least one hospitalization of 60 continuous days within the past year.
- Having had DSS substantiated abuse, neglect or dependency within the past year.
- Having been expelled from two or more daycare or pre-kindergarten situations within the past year.
- Having been adjudicated or convicted of a felony or two or more Class A1 misdemeanors in juvenile or adult court or placed in a youth development center, prison, juvenile detention center or jail within the past year.

- Situation exacerbated by special needs (e.g. physical disability that substantially interferes with functioning).

NOTES: This target population was designed to cross walk with Level D in the Child Levels of Care document (March 2002). For additional information please refer to this document.

Also for additional clarification regarding specific terminology used in eligibility determination, please refer to the Child Mental Health IPRS Eligibility Clarification document.

An individual determined eligible for this target population will have priority for funding if identified as:

- Sexually aggressive; and/or
- Deaf; and/or
- Having co-occurring disorders.

Seriously emotionally disturbed child (CMMED)

Child, under the age of 18, with atypical development (up to age five) or serious emotional disturbance (SED) by the presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9;

AND

Functional impairment that seriously interferes with or limits his/her role or functioning in family, school or community activities as evidenced by one or more of the following:

- CAFAS score of at least 60; **OR**
- Total CAFAS score greater than or equal to 40 and it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.

NOTES: This target population was designed to cross walk with Level C in the Child Levels of Care document (March 2002). For additional information, please refer to this document.

Deaf or hard of hearing child (CMDEF)

Child, under the age of 18, who is assessed as deaf or as needing specialized mental health services due to social, linguistic or cultural needs associated with individual or familial deafness or hearing loss;

AND

The presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9.

NOTES: Deaf children will be dually enrolled as both Deaf/HH and in their appropriate population category, or order to receive a full array of services. Where this funding is available, it will be depleted before other funding sources pay for the eligible service.

Homeless child – PATH (CMPAT)

Child, under the age of 18, who has serious emotional disturbance (SED) and has an ICD-9 diagnosis(es) and is:

Homeless, as defined by:

- Lacks a fixed, regular, adequate night-time residence; **OR**

- Has a primary night-time residence that is:

  (a) Temporary shelter; **or**

  (b) Temporary residence for individuals who would otherwise be institutionalized; **or**

  (c) Place not designed/used as a regular sleeping accommodations for human beings.

OR

At imminent risk of homelessness as defined by:

- Due to be evicted or discharged from a stay of 30 days or less from a treatment facility

AND

- Who lacks resources to obtain and/or maintain housing.

NOTES: There is no specific requirement regarding functioning as measured by a CAFAS score. Assertive outreach can be provided to homeless persons who have a deferred diagnosis.

Developmental Disabilities

The Division's developmental disabilities services follow recommendations of the National Association of State Directors of Developmental Disabilities Services and use the University of Minnesota's figure of 1.58 percent as a broad estimate of people in the total population with developmental disabilities. This means that there are approximately 130,810 people in NC with developmental disabilities.

Adult with developmental disability (ADSN)

Adult, ages 18 and over, screened eligible as developmentally disabled in accordance with the current functional definition in G.S. 122C-3(12a).

Developmental disability assessment based on NC SNAP 1 through 5.

NOTES:

Developmental disability means a severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and,
- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services that are of a lifelong or extended duration and are individually planned and coordinated.

Child with developmental disability (CDSN)

Child, under the age of 18, screened eligible as developmentally disabled in accordance with the current functional definition in G.S. 122C-3(12a).

Developmental disability assessment based on NC SNAP 1 through 5.

NOTES: Developmental disability means a severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and,
- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services that are of a lifelong or extended duration and are individually planned and coordinated.

Substance Abuse

Data used in making projections of treatment needs are taken from North Carolina's first Center for Substance Abuse Treatment (CSAT) needs assessment studies conducted by the Research Triangle Institute. Estimates of people needing substance abuse services include:

- 784,000 people age 18 and above who needed substance abuse services.
- 2,600 homeless.
- 2,700 psychiatric patients.
- 9,700 imprisoned believed to be in need of substance abuse services.
- 47,555 public high school students.
- 4,917 school dropouts.
- 666 private school students.

The most significant opportunity to reduce the burden of substance abuse on public programs is through targeted and effective prevention programs. If children and youth under age 21 can be kept from smoking cigarettes, using illicit drugs and abusing alcohol, the risk for future addiction is substantially reduced. Treatment is also a cost-effective intervention, as it reduces the costs to state programs in the short term and avoids future costs. North Carolina will make targeted interventions for selected populations that hold promise for high return. As savings and new resources become available to expand service system capacity, additional populations will be added to the list of those targeted for services.

All individuals will be assessed for service eligibility on the basis of the American Society of Addiction Medicine (ASAM) patient placement criteria for the treatment of substance-related disorders (PPC).

Adult Substance Abuse

Adult injecting drug user/communicable disease (ASCDR)

Injecting drug users, those with communicable disease and/or those enrolled in opioid treatment programs, are those adults who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, and:

- Who are currently (or within the past 30 days) injecting a drug under the skin, into a muscle or into a vein for non-medically sanctioned reasons and who meet ICD-9 criteria for a substance-related disorder.

OR

- Who are infected with HIV, tuberculosis or hepatitis B, C or D and who meet ICD-9 criteria for a substance-related disorder.

OR

- Who meet ICD-9 criteria for dependence to a opioid drug, are addicted at least one year before admission, are 18 years of age or older, and who are enrolled in an opioid treatment program.

Adult substance abuse women (ASWOM)

Adult women who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, with an ICD-9 substance-related disorder who are:

- Currently pregnant.

OR

- Have dependent children under 18 years of age.

OR

- Who are seeking custody of a child under 18 years of age.

Adult substance abuse DSS-involved parents (ASDSS)

DSS involved adults who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, and are substance abusers who meet ICD-9 criteria for substance-related disorder include those who:

1. Are parents who have legal custody of a child or children under 18 years of age.

   AND

2. Where there is a Child Protective Services report for child abuse, neglect or dependence that is being assessed, or where there is a finding of a need for Child Protective Services or a case decision of substantiation by Child Protective Services, OR who are authorized by DSS to receive Work First Assistance and/or services.

OR

Are DSS involved individuals who have been convicted of a Class H or I Controlled Substance Felony in North Carolina, and who are applicants for or a recipient of food stamps.

Adult substance abuse high management (ASHMT)

High management adult substance abusers, who are in need of treatment for a primary alcohol or drug abuse disorder, with an ICD-9 substance dependence disorder, are those individuals who are ages 18 and over, and who:

(1) Are currently involuntarily committed to substance abuse treatment (legally determined to be dangerous to self or others and may have co-occurring mental illness).

OR

Have a substance use pattern of recurring episodes of chronic use with unsuccessful attempts at recovery (or unsuccessful attempts by the provider to engage the chronically ill individual in treatment).

AND

Have a history of one or more unsuccessful treatment episodes, which may include assisted detoxification. The individual is advanced in their disease, has limited social or environmental supports, and has few coping skills. The individual may also be resistive to treatment, or have co-occurring disorders, or have moderate biomedical conditions.

Adult substance abuse criminal justice offender (ASCJO)

Substance abusing adult clients who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, who are involved in the criminal justice system, and:

Who meet ICD-9 criteria for a substance-related disorder;

AND

Whose services are approved by a TASC program care manager;

AND

Who voluntarily consent to participate in substance abuse treatment services;

AND

(1) Who are Intermediate Punishment offenders, **or**

(2) Who are Department of Correction releasees (parole or post-release) who have completed a treatment program while in custody, **or**

(3) Who are Community Punishment Violators at-risk for revocation.

Adult substance abuse driving while impaired treatment (ASDWI)

Adults, ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, who have an ICD-9 substance-related disorder and:

1. Have been arrested for:
   - Driving while impaired (DWI), **OR**
   - Commercial DWI, **OR**

- Driving while less than 21 years old after consuming alcohol or drugs.

AND

1. Must have completed a DWI assessment and been identified with a substance abuse handicap.

AND

2. Client must pay for initial $125 in fees for assessment and treatment.

AND

3. Have an income level of 200% or less of the federal poverty level.

Note: The intent of this eligibility category is to provide necessary access to treatment for eligible individuals who cannot pay for services through first or third party payment and who are seeking substance abuse treatment that is required in order for the individual to obtain a Certificate of Completion required under General Statute as a condition for the restoration of a driver's license.

Adult substance abuse deaf and hard of hearing (ASDHH)

Adult clients who are ages 18 or over, who are in need of treatment for a primary alcohol or drug abuse disorder, and who have an ICD-9 substance-related disorder and who have been assessed as having special communication needs because of deafness or hearing loss.

Adult substance abuse homeless (ASHOM)

Adult clients who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder and who meet the criteria for any of the following IPRS target population categories:

- Injecting drug user/communicable disease risk (ASCDR)
- Criminal justice offender (ASCJO)
- DSS-involved (ASDSS)
- DWI treatment (ASDWI)
- High management (ASHMT)
- Women (ASWOM)
- Deaf and hard of hearing (ASDHH)

AND IS

Homeless, as defined by:

1. Lacks a fixed, regular and adequate nighttime residence.

   OR

4. Has a primary night-time residence that is:
   - Temporary shelter, **or**
   - Temporary residence for individuals who would otherwise be institutionalized, **or**

- Place not designed/used as a regular sleeping accommodations for human beings.

OR

At imminent risk of homelessness as defined by:

1. Due to be evicted or discharged from a stay of 30 days or less from a treatment facility.

AND

5. Who lacks resources to obtain and/or maintain housing.

Child and Adolescent Substance Abuse

Child with substance abuse disorder (CSSAD)

Child or adolescent, under the age of 18, who is in need of treatment for a primary alcohol or drug abuse disorder, with a primary ICD-9 substance-related disorder.

Child Substance Abuse Women (CSWOM)

Adolescent women who are under the age of 18, who are in need of treatment for a primary alcohol or drug abuse disorder, with a primary ICD-9 substance-related disorder, and who are:

- Currently pregnant.

OR

- Have dependent children under 18 years of age in her custody or for whom she is seeking such custody.

Child substance abuse selective prevention (CSSP)

A child or adolescent under 18 years of age determined to be at elevated risk for substance abuse and who:

- Is currently experiencing, or in the previous six months has experienced, documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion or dropping out of school

OR

- Has documented negative involvement within the previous six months with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning, or escort.

OR

- Has one or both parents, legal guardians, or caregivers that have one or more documented child abuse or neglect reports, investigations or substantiated incidents involving DSS.

OR

- Has one or both parents, legal guardians, or caregivers that have a documented substance-related disorder.

NOTE: Individuals do not meet criteria for a substance-related disorder or a mental health disorder, but may meet the criteria for other conditions that may be a focus of clinical attention. Recipients will be individually identified, client records will be maintained, and designated consumer prevention outcomes will be tracked.

Child substance abuse indicated prevention (CSIP)

Child or adolescent under 18 years of age who is using alcohol or other drugs at a pre-clinical level (child or adolescent does not meet criteria for a substance-related disorder or a mental health disorder, but may meet other criteria) and who:

- Is currently experiencing, or in the previous six months has experienced, documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion or dropping out of school.

OR

- Has documented negative involvement within the previous six months with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning or escort.

OR

- Has one or both parents, legal guardians or caregivers that have one or more documented child abuse or neglect reports, investigations or substantiated investigations involving DSS.

OR

- Has one or both parents, legal guardians or caregivers that have a documented substance-related disorder.

NOTE: Individuals do not meet criteria for a substance-related disorder or a mental health disorder, but may meet other criteria. Recipients will be individually identified, client records will be maintained, and designated consumer prevention outcomes will be tracked.

Child substance abuse criminal justice offender (CSCJO)

Substance abusing adolescent clients who are under the age of 18, who are in need of treatment for a primary alcohol or drug abuse disorder, and who are involved in the criminal justice system and:

- Who have a primary ICD-9 substance-related disorder.

AND

- Whose services are authorized by a TASC program care manager.

AND

- Who voluntarily consent to participate in substance abuse treatment services.

AND

- Who are Intermediate Punishment offenders OR who are Department of Correction releasees (parole or post-release) who have completed a treatment program while in custody OR who are Community Punishment Violators at-risk for revocation.

Child substance abuse DWI Treatment (CSDWI)

Adolescents under the age of 18, who are in need of treatment for a primary alcohol or drug abuse disorder, who have a primary ICD-9 substance-related disorder and:

1. Have been arrested for:
   - Driving wile impaired (DWI), **or**
   - Commercial DWI, **or**
   - Driving while less than 21 years old after consuming alcohol or drugs.

AND

2. Must have completed a DWI Assessment and been identified with a substance abuse handicap.

AND

3. Client must pay for initial $125 in fees for assessment and treatment.

AND

4. Have an income level of 200% or less of the federal poverty level.

NOTE: The intent of this eligibility category is to provide necessary access to treatment for eligible individuals who cannot pay for services through first or third party payment and who are seeking substance abuse treatment that is required in order for the individual to obtain a Certificate of Completion required under General Statute as a condition for the restoration of a driver's license.

Child in the MAJORS substance abuse/juvenile justice program (CSMAJ)

Child or adolescent, under the age of 18, who is in need of treatment for a primary alcohol or drug abuse disorder, with a primary ICD-9 substance-related disorder.

AND

Is enrolled in the MAJORS substance abuse/juvenile justice program.

Priorities within Target Populations

- Adult and child pregnant injecting drug users.
- Adult and child pregnant substance abusers.
- Adult and child injecting drug users.
- Children and adolescents who are involved in the juvenile justice or the social services system, who are having problems in school or whose parent(s) are receiving substance abuse treatment services.
- Adult and child deaf persons who need special services provided by staff who have American Sign Language skills and knowledge of the deaf culture.

- Adult and child clients who have co-occurring physical disabilities.
- Adult and child homeless clients
- All others.

Persons with Substance Abuse and Mental Illness

LMEs will be required to ensure that services are provided to individuals who experience substance abuse problems along with co-existing physical or cognitive disability. All services to adults with multiple disorders should address both the mental health and substance abuse needs in a coordinated, integrated manner. The primary responsibility shall be assigned as described here:

- Adult mental health services shall have primary responsibility for mentally ill individuals who also abuse substances. This includes adults who have a diagnosis of severe and persistent mental illness, including schizophrenia, bipolar disorder, schizoaffective disorder, recurrent major depression or borderline personality disorder, and in addition have a substance abuse problem.
- Substance abuse services shall have primary responsibility for consumers with substance abuse/dependence disorders who also have a mental illness. This includes adults who carry a diagnosis of substance abuse/dependence and, in addition, have a mental health diagnosis other than those listed above, which could include other Axis II disorders.

Chapter 2. Organizational Structure of the Public MH/DD/SAS System

The Joint Legislative Oversight Committee on MH/DD/SAS

The North Carolina General Assembly has been actively involved in reform efforts of the public system of mental health, developmental disabilities and substance abuse services beginning with the establishment of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) to oversee system reform. The Legislative Oversight Committee was instrumental in the creation and ratification of the mental health reform statute (House Bill 381: An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level). Since the enactment of the reform legislation, the LOC has met on a regular basis to receive input from the leadership of the Department and the Division and from the public on the status of the reform efforts. In addition, the Division provides quarterly reports to the LOC on matters related to implementation of the reform.

The North Carolina Commission for MH/DD/SA Services

The Commission was created by the General Assembly. The Commission advises the Secretary of Health and Human Services about the need for, provision and coordination of education, prevention, intervention, treatment, rehabilitation and other services in the area of mental illness, mental health, developmental disabilities and substance abuse. The Commission has authority to make rules for:

- Operating local area mental health, developmental disabilities and substance abuse programs.
- Admission, care and treatment of people in residential facilities operated by the Division.
- Licensing facilities for people with mental illness, developmental disabilities or substance abuse problems, including the professional requirements of staff.
- Registration and control of the manufacture, distribution and dispensing of controlled substances.
- Implementing clients' rights law.
- Establishing human rights committees.
- Mental health and mental retardation services for people in the custody of the Department of Correction.

There are 30 members on the Commission, each serving a three-year term. Each congressional district is represented and the Governor appoints 24 members.

The Division of MH/DD/SAS

The Division has completed a reorganization that contains fewer layers of management and is designed to promote and accommodate the reformed system statewide. The Division's organizational structure is designed to implement the State Plan and reform efforts. The substance of the Division's goals and objectives will guide the development of the workings of the Division and that work will be carried out through this organizational structure.

The Division's central administration consists of the Director's Office and five sections organized along functional lines. The five sections of the Division are State Operated Services, Community Policy Management, Resource/Regulatory Management, Advocacy and Customer Services, and Administrative Support. The Division's state facilities consist of four regional psychiatric hospitals, four developmental disabilities centers, three substance abuse treatment centers, a specialty nursing facility for mentally ill consumers, a specialty nursing facility for consumers with developmental disabilities and two residential facilities for children with emotional disturbances.

State Operated Services

The Division holds a dual role as manager and provider of state-operated services and facilities and is held to the same quality and best practice standards, as are local management entities (LMEs).

State-operated services and facilities will be organized into three regions - West, Central and East - to allow for a more effective and efficient system. Responsibilities of the section include:

- Defining the purpose, roles, and responsibilities of state-operated services.
- Developing a system for regional planning.
- Carrying out administrative consolidation efforts that promote increased efficiencies and effectiveness as required by the reform statute and state 2001 appropriations bill.
- Managing admissions and discharge planning of state-operated facilities.
- Determining roles and responsibilities for developing partnerships with regional advocates, LMEs, area programs, counties, provider systems and Division stakeholders.
- Making census reduction plans and corresponding budget reduction plans for state-operated services that include considerations of impact on state employment and efforts to work with local communities regarding the economic implications.
- Devising statewide standards for each type of state operated service (by disability group and within unique programs) that reflect best practice and that are understandable, accountable, appropriate, efficient, effective and consistent with regulatory and accreditation compliance, performance and outcome expectations.

Community Policy Management

This section is primarily responsible for leadership, guidance and oversight of the community based service delivery system. This section collaborates with a wide variety of public and private partners to promote recovery through the reduction of stigma and barriers to services. The section performs the functions of the single state agency (SSA) for substance abuse and of the state methadone authority. The teams in the section are as follows.

Employee Assistance Program (EAP) provides support for Department employees and their families and influences the development of effective EAPs in communities.

Quality Management Team establishes for the Division, state operated facilities, LMEs, providers and contracts the standards of quality and required performance measures specifying how quality is defined, monitored and managed.

Best Practice and Community Innovations Team is responsible for improving and strengthening the system through the development of best practice platforms and models and establishing a system that more effectively connects services and research with the goal of providing treatment, services and supports based on the best scientific evidence.

Local Managing Entity Systems Performance Team The responsibilities of this team include leading and coordinating the Division's efforts to develop, negotiate, monitor and manage contracts with the local managing entities (LMEs); and coordinating across Division teams to conduct scope reviews of LMEs when there is evidence of problems with specific areas of best practice or emerging best practice or compliance, performance and/or outcomes.

Justice System Innovations Team continuously researches, disseminates and advances best and innovations in criminal justice programs relative to mental health, developmental disabilities, substance abuse and specialty supports and services.

Prevention and Early Intervention Team is the designated Office of Substance Abuse Prevention. This team also develops an appropriate evidence based prevention framework for mental health and developmental disabilities. Additionally, the team is responsible for early intervention services for children.

Resource/Regulatory Management

This section is responsible for supporting the efforts and ensuring accountability of the operations components of the Division including State Operated Services, Community Policy Management, Advocacy and customer Services and Administrative Support. The teams in this section include the following.

Budget and Finance Team This team is responsible for managing the budget (expenditure) and financial (revenue) operations for the Division.

Information Systems Team This team is responsible for comprehensive planning, development, implementation and management of the Division's computer network, warehouse, hardware, software and technical support functions.

Accountability Team This team is responsible for ensuring Medicaid and overall fiscal and programmatic integrity within the Division including state-operated services and the community system.

Regulatory Team This team is responsible for ensuring regulatory compliance by the various components of the Division, including:

- Coordination of Medicaid waiver and State Plan developments with DHHS.
- Management of Division responsibilities regarding DWI and drug enforcement.
- Completion of pre-admission screening and annual resident reviews (PASARR).
- Completion of Intermediate Care Facility-Mental Retardation (ICF-MR) and level of care (LOC) determinations.
- Completion of provider enrollments.
- Provision of interpretations of federal and state regulations.

Contract Management and Development Team This team supports the implementation of the State Plan in two primary areas:

- Ensuring contracts are performance based, monitored and developed in accordance with all state and federal requirements.
- Managing property, maintenance, surplus disposal and purchasing.

Advocacy and Customer Services

This section leads the Division's efforts to create a community where people with disabilities are valued and treated with dignity; and where stigma, accompanying attitudes, discrimination and other barriers to recovery are eliminated. The teams in this section include the following:

State Facility Advocates Team This team is responsible for ensuring that the rights of consumers in all state operated facilities are protected. Advocates manage case investigations and system improvement efforts for advocacy services.

Customer Services and Community Rights System Team This team has three key responsibilities:

- Ensuring the rights protection of consumers being served in the community
- Providing a response system for customer complaints.

- Monitoring the community customer services systems.

Consumer Empowerment Team This team is responsible for the following:

- Ensuring consumer and advocacy voice and disability representation in Division planning, implementation, management and improvement efforts.
- Assisting in the development of local grass roots consumer controlled advocacy groups and organizations.
- Providing technical assistance and consultation to local consumer and family advisory committees (CFACs).
- Monitoring the efforts and achievements of the local CFACs to ensure their empowerment to perform their role/responsibilities.
- Providing support and technical assistance to self-advocacy initiatives.

Administrative Support

This section is responsible for providing administrative support and ensuring coordination with DHHS for the operations components of the Division, including Advocacy and Customer Services, Community Policy Management, State Operated Services and Resource/ Regulatory Management. Teams in this section include the following.

Planning Team This team is responsible for:

- Providing technical oversight and coordination in implementing and managing the State Plan.
- Providing technical oversight and coordination in implementing the current state fiscal year's Operations Plan.
- Providing a range of technical planning assistance (from brief consultation to plan management) for all Division planning endeavors.
- Serve in the role Project Manager for specific initiatives.
- Coordinate the Division's disaster preparedness, response and recovery activities.
- Coordinate the development of grant applications to federal and private funding sources.

Division Affairs Team This team is responsible for:

- Advancing collaborative efforts among divisions of the Department.
- Participating in and creating new partnerships to foster reform.
- Coordinating the development of rules, policy and legislation of the Department.
- Managing and monitoring Division programmatic due process appeals functions.
- Staffing and supporting the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services.

- Serving as the liaison for all commissions, advisory councils and planning groups associated with the Division.

Communication and Training Team This team is responsible for:

- Increasing public awareness regarding the efforts of the Division, particularly as related to reform.
- Coordinating media relations for the Division with the Department.
- Developing and disseminating information and communications regarding Division activities (annual report, newsletters, brochures, etc.).
- Developing a comprehensive training plan for advancing Division members' competencies in coordination with Human Resources.
- Developing training opportunities necessary for carrying reform efforts.
- Serving as the liaison to universities, community colleges and AHECs to facilitate training for the State plan.
- Developing strategies to address workforce issues.

Community Services

Community based mental health, developmental disabilities and substance abuse services are provided through a network of 33 area/county programs, which cover the state's 100 counties. These area/county programs are in the process of making the transition from being primarily service providers to becoming local management entities (LMEs) that oversee and manage the local mental health system and policy. The area/county programs are separate local governmental entities (with three exceptions) and are governed by boards appointed by their respective boards of county commissioners. Statutorily, the area/LME boards are responsible for, among other things, planning, budgeting, implementing and monitoring community based mental health, developmental disabilities and substance abuse services.

Chapter 3. Progress of Reform to Date

The first major reform of North Carolina's public system in more than thirty years was developed in response to the passage of Session Law 2001-437. Over the past three years staff of the Division have been working to develop the infrastructure needed to enact this sweeping legislation. This chapter provides a status report on activities to date to prepare the community system, state facilities and the Department to implement reform.

Status of the Community System

Prior to July 1, 2003, community mental health, developmental disabilities, and substance abuse (mh/dd/sa) service delivery in North Carolina remained virtually unchanged since the mid-1980s. Each area of the state was served by an area authority (in the two largest counties of the state by a consolidated human service agency per N.C.G.S. 122C-127), with the statutory authority of an entity of local government. The area authority followed the community mental health model – the entity employed clinical staff and delivered rehabilitation option and clinic-based services.

The reform legislation called for a phased approach by which each area program was required to submit letters of intent indicating its preference of a governance model and which phase it would participate in. Thirteen area programs chose to participate in Phase I that began July 2003, three area programs chose Phase II that began Jan. 2004 and fifteen area programs chose Phase III that will begin July 2004. During fiscal year 2003-2004, all area programs were sent certification letters regarding their status as an LME and status regarding the certifications of their local business plans.

Staff of the Division has been working to build an infrastructure that will enable system transition in a manner that is least disruptive to services delivery for citizens of the state. Many discrete operational activities have been undertaken to move reform forward. The transition process for serving target and non-target populations has included completing consumer assessments to determine whether individuals qualify for target and non-target populations. Citizens will receive services that reflect best practice. Service delivery will be determined by a collaboratively developed person-centered plan. During the transition period, Division staff will provide technical assistance around natural and community supports for non-target individuals. A key element of system reform is to ensure that individuals that fall outside of the target populations are appropriately assessed and effectively linked to alternative community resources. **It is very important for area programs, LMEs and consumers and families to understand that services will not be divested until an area program has the adequate provider/providers in place to provide the services needed so that consumers' treatment and supports are not disrupted or discontinued.**

The Division is working on a long-term finance strategy. This strategy will be a comprehensive funding plan that outlines the use of local funds - the county maintenance of effort and third party benefits.

Status of the State Facilities

Much of the work on building community capacity is occurring in connection with the state's *Olmstead Plan. Olmstead* refers to the 1999 U.S. Supreme Court decision that held that unnecessary institutionalization is a violation an individual's rights under the Americans with Disabilities Act. In response to the Courts decision, North Carolina developed its *Olmstead Plan.* As part of the state's *Olmstead Plan*, the Division established a process for assessing all qualified individuals residing in state psychiatric institutions, developmental centers and community based Intermediate Care Facility-Mental Retardation (ICFs-MR), and for assessing individuals at risk of institutionalization. From these, both individual service planning and aggregate community capacity needs can be determined. Using the results of these needs assessments, the staffs of state facilities, the Division and LMEs are working to develop community capacity to provide services and supports that will be needed by those returning to the community.

Olmstead Plan Implementation

During state fiscal year 2004, the Division continued to complete Olmstead assessments with individuals who had been hospitalized for 60 or more days. Each Olmstead assessment consisted of a standardized level of care assessment, individual preference interview and individualized service plan developed by the individual, hospital treatment team, area program/LME staff and, if applicable, guardian. The outcome of each assessment was a projection of the services and supports the individual would need to successfully return to the community. When the individual is ready for discharge, information from the assessment is used during discharge planning. In aggregate, information from the Olmstead assessments helps inform the area program/LME's planning process for community capacity expansion.

Olmstead assessments were also completed with individuals residing in community ICFs-MR. Approximately half of the individuals in these facilities were assessed during state fiscal year 2002-2003 with the remainder assessed during state fiscal year 2003-2004.

The Division monitors the community tenure of individuals discharged from the state hospitals through the downsizing/Olmstead process. To accomplish this, three monitoring mechanisms have been developed and implemented. First, all discharge plans of long-term patients are reviewed and approved by Division staff prior to discharge from a hospital. Second, the LME monitors consumer outcomes after discharge according to the following schedule: monthly for the first six months post-discharge, quarterly for the next three quarters, and annually thereafter. A secure web-based application has been developed for LMEs to enter outcome data. Outcomes monitored include placement type and tenure, employment-related activities, hospitalization and crisis visits, and involvement with the criminal justice system. Third, Division staff make periodic visits to LMEs to monitor the progress of selected discharged individuals. Updates are obtained from clinicians serving each individual, and Division staff meet face to face with selected individuals. The goal is to meet with a sample of 25% of discharged individuals.

Community Expansion and Psychiatric Hospital Downsizing

A variety of steps have been taken to support the expansion of community capacity and reduce the reliance on regional state psychiatric hospitals. First, all long-term patients in state hospitals have been assessed for potential community placement, and service plans have been developed as appropriate under the Department's *Olmstead Plan*, as noted above. These individual patient assessments and service plans have been used in planning community service expansion. Second, relevant divisions within DHHS are working to develop a specialty nursing facility service model for those patients whose mental health needs exceed the capacity of existing nursing home models. Plans are being finalized by DMH/DD/SAS and the Division of Medical Assistance to implement an enhanced unit of 20 beds in the East to support downsizing of Cherry Hospital's nursing beds and to serve as a model for developing a state-wide level of care. This model is scheduled for implementation in early state fiscal year 2004-2005. Third, DMH/DD/SAS is developing specialty services for those elderly patients who need a non-nursing facility congregate living setting, but whose mental health needs exceed the capacity of current congregate living models. Fourth, the Mental Health Trust Fund has been accessed in state fiscal years 2001-2002, 2002-2003, and 2003-2004 to provide start-up funding needed to facilitate the movement of clients from state hospitals to community settings.

In state fiscal year 2002-2003, each state hospital catchment region established a regional structure to identify and plan for the array of community-based services to support reduced reliance on the state hospitals. Expansion plans were submitted to the Division, and Trust Fund dollars were allocated for start-up of services for patients coming out of long-term beds. A total of 142 beds were closed by the end of state fiscal year 2002-2003, including 79 adult long-term, 47 long-term geriatric and 16 nursing facility. After bed closure, recurring funds in state fiscal year 2003-2004 in the amount of $9,236,886 were redirected from the state hospitals to LMEs to support the services initially funded by the Trust Fund.

To support downsizing activities in state fiscal year 2003-2004, Division staff met with area program staff to develop proposals for community service expansion. Proposals were submitted for review and approval beginning in November 2003. Allocations from the Trust Fund for community capacity expansion were made beginning in January 2004 and completed by April 30, 2004 totaling to $2,507,933. At end of state fiscal year 2003-2004, a total of 172 beds are scheduled for closure, including 81 adult long-term, 44 geriatric long-term, and 47 nursing facility. As shown on the following table, these closures will generate $7,980,915 in hospital savings to be re-directed to the community in state fiscal year 2004-2005 as additional recurring funds.

Trust Fund and Hospital Downsizing Savings Allocations for Community Capacity Expansion			
	MH Trust Fund for Start-Up[1]	Allocations from Previous FY Downsizing Savings[2]	Cumulative Savings Allocations
FY2002	$671,000		
FY2003	$3,862,286	$1,800,000	$1,800,000
FY2004[3]	**$2,507,933**	$9,236,886	$11,036,886
FY2005[3]		**$7,980,915**	**$19,017,801**
[1]One-time funds			
[2]Recurring funds			
[3]Includes Piedmont funding			
Boldface are projected amounts			

Bed Day Allocation Plan

In an effort to reduce over-reliance on institution-based care, plans for community capacity expansion and hospital downsizing have been developed and implemented. State psychiatric hospital beds have been scheduled for reduction through state fiscal year 2005-2006. To ensure appropriate utilization of decreasing state hospital beds as well as alcohol and drug abuse treatment center (ADATC) beds, the Division implemented a revised bed day allocation plan on July 1, 2003. This plan initially allocates existing bed days across LMEs according to historical utilization of the four psychiatric bed day categories, adult admission, adult long-term, geriatric, and child and one substance abuse category. Over the next three years, the number of bed days allocated for psychiatric beds tracks the downsizing schedule, so that fewer bed days are available after closure of beds at the end of the previous year. In addition, the basis for allocation of bed days changes from historical utilization to the population of the LME.

New Hospital Planning

In March 2002, Department of Health and Human Services Secretary Carmen Hooker Odom announced plans to realign Dorothea Dix and John Umstead Hospitals to promote construction of a new, state-of-the-art hospital serving the central region of North Carolina. In September 2002, the Secretary selected Butner as the site of the new hospital after reviewing four sites in the central part of the state, Butner, Raleigh, Siler City and Pittsboro. Butner was selected as the site for the 432-bed facility based on the availability of a skilled work force, proximity to Duke and UNC research and training facilities, availability of utilities, availability of state-owned property or reasonably priced land, access to major state highway routes and client access.

DHHS selected the architectural planning team of The Freelon Group/Cannon Design to develop the central facility at Butner. The project was initiated in October 2002 and is scheduled to be completed by May 2007.

Community Expansion and Developmental Center Downsizing

Last year's plan stated that the State Operated Services section is responsible for ensuring exemplary practice related to the operations of state facilities and the transition from state-operated services to community capacity developments.

Developmental center downsizing goals

- Services should be provided in the most integrated community setting suitable to the needs and preferences of the individual and planned in partnership with the individual and/or family.
- Individuals should receive the services needed based on a person-centered plan and in consideration of any legal restrictions, varying levels of disability, and fair and equitable distribution of system resources.

Activities to achieve these goals include:

1. Development of a community planning initiative to achieve downsizing:
   - October 2003 memorandum from Dr. Visingardi provided foundation for initiative, included purpose and process for plan submission.
   - State downsizing plan completed and submitted to Legislative Oversight Committee in January.
   - $2.5 M from MH Trust Fund designated for MRC downsizing/community capacity development.
2. Community capacity plans:
   - Community plans submitted by 29 LMEs.
   - LMEs commit to move 149 individuals from their regional MRCs by June 30, 2005 (average of 10% downsizing of individuals from LMEs' designated regional facility; does not reflect 10% aggregate statewide downsizing).
3. Trust Fund Requests/Allocations:
   - Funds requested for individual start-up, staff training, LME staff, service start-up, and group home development.
   - Requests for individual start-up costs (i.e. furniture or equipment purchase, provider staff training) are being approved to facilitate movement when appropriate community placement has been identified and secured.
   - As of April 1, 2004, one LME community plan has been approved.
   - Follow-up conference calls/visits in May and June 2004 with each LME to provide technical assistance regarding community plans, negotiate funding requests, etc.

Status of Departmental/Division Efforts

During the past three years the Division has partnered with many entities to advance reform efforts. These partnerships have been formed with other state agencies and private associations such as the divisions of Medical Assistance, Facility Services and Vocational Rehabilitation, the NC Council of Community Programs, the NC Association of County Commissioners and other professional and consumer organizations.

Three venues have been established to ensure ongoing input to the reform effort. First an external Stakeholders Group was appointed by Secretary Carmen Hooker Odom. The group was established to assist the Division with necessary policy development as part of mental health reform implementation. The Stakeholders Group includes representatives of the various parties to reform. Each of the disability sub-coalitions of Coalition 2001, area program directors, the NC Council of Community Programs, the NC Association of County Commissioners, providers and advocates make up the membership of the group.

Second, a Public Partners Policy Group was established to address issues related to reform that are of concern to the public partners of the mental health, developmental disabilities and substance abuse services system. The group is comprised of representatives of the Department of Health and Human Services, area/county programs, county managers and county commissioners.

Third, the Department has established a state level Consumer and Family Advisory Committee (S-CFAC). The S-CFAC in conjunction with the Division's Executive Leadership Team (ELT) will provide input and conduct oversight of the Division's operations and efforts to accomplish the strategic outcomes of the State Plan. Participation at the state level ensures direct access to the ELT to bring forward the concerns and input of the local CFAC groups in their communities. The S-CFAC reports directly to the DHHS Secretary and will meet with the Secretary at least annually to provide a summary of the S-CFAC's perspective regarding Division efforts.

Information Technology/Services

Implementation of mental health reform requires that the Division have access to accurate and relevant information that can be presented in a user-friendly manner. The need to collect and analyze management and financial data for planning, establishing benchmarks, measuring individual and systems outcomes and information decision making has been identified. To support the work of the Division, LMEs and state facilities, the Division's information technology efforts have centered on the development of the Integrated Payment and Reporting System (IPRS), the Medicaid Management Information System (MMIS) and the Healthcare Enterprise Accounts Receivable and Tracking System (HEARTS), in addition to compliance with HIPAA requirements. The status of each of these information technology initiatives are as follows.

<u>Integrated Payment and Reporting System</u>

The Division initiated implementation of the Integrated Payment and Reporting System (IPRS) in 2002. This system replaced the outdated Pioneer system and four other program

specific billing systems. The IPRS is designed to be a HIPAA compliant, multi-payer system integrated with the state's Medicaid payment system, providing providers of services the ability to send one bill to the state for payment of state or federal monies. The system provided a tool to solve many of the technical problems of information and data collection management. IPRS uses Internet and mainframe technology to process, track, pay and report all claims submitted by providers for services rendered to constituent populations. IPRS was originally piloted in two area programs and began statewide rollout on July 1, 2002. Statewide implementation was completed on November 30, 2003 and has moved to production status. This system will be replaced with the implementation of the new MMIS+ system.

Medicaid Management Information System

The Medicaid Management Information System (MMIS) is the state's Medicaid reimbursement system. This system was recently upgraded to include the multi-payer functionality of the IPRS for reimbursement of state and federal block grant dollars on state approved mh/dd/sa services. In 2003 the state developed and posted an RFP to replace the current system focusing on ease of use and maintenance, flexibility, modern technology and cost reduction. Affiliated Computer Services, Inc. (ACS) successfully won the bid, replacing the current vendor Electronic Data Systems (EDS). Beginning June 1, 2004, a two-year effort will kick off to modify and implement the new system. Current schedule calls for the first Medicaid check write to occur in the first week of July 2006.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted as a Congressional attempt to reform healthcare. The purpose of HIPAA is to: improve portability and continuity of health insurance coverage in the group and individual markets; combat waste, fraud, and abuse in health insurance and health care delivery; and simplify the administration of health insurance, as well as other purposes. The HIPAA regulations are designed to improve the efficiency and effectiveness of the healthcare system by standardizing the interchange of electronic data for specified administrative and financial transactions and to protect the security and confidentiality of health information.

The Division and state facilities are currently participating in the Department's HIPAA validation surveys to determine compliance status toward the privacy regulations. The Department's timeframe to complete these validation surveys is by June 30, 2004. As with the privacy regulations, the Department is also leading the efforts toward compliance with the security regulations. In addition to working on security compliance, the Division will also work closely with the state facilities to assist them with compliance with security regulations. Another HIPAA regulation was recently released. The National Provider ID regulation was recently released with a compliance date of May 23, 2007. The Division will work closely with the Department to ensure compliance by that date.

Healthcare Enterprise Accounts Receivable and Tracking System

The Healthcare Enterprise Accounts Receivable and Tracking System (HEARTS) is the single billing and information system used in all facilities, ensuring an adequate interface of all applications with IPRS and Medicaid payment systems. HEARTS is the primary hospital information system used in the Division's state operated facilities. This system is responsible for processing the billing of over 350 million dollars in patient/consumer services.

Components of the system for patient clinical care management have not been implemented. The Division has initiated a project to address the clinical and patient care system at the facilities. The Clinical Care Workgroup comprised of personnel from the DMH/DD/SAS, the Division of Information Resource Management, the Controller's Office and each facility has been formed to oversee this effort.

Chapter 4. Goals and Objectives for State Fiscal Year 2004-2005

Thirty-seven key developments have been identified for SFY 2004-2005 that will enable the Division to continue to move reform forward. These key developments have been categorized into four areas. These four areas are Management and Leadership, Finance, Programmatic Issues and Administration and Contracts. Each of the four areas has an overall outcome and the specific developments that must be completed to support that outcome. The details of how these key developments will be accomplished are described in the remainder of this chapter.

Management and Leadership

Outcome:

To implement a structure to operationalize the State Plan that ensures integration, communication, coordination and transition for the various stakeholders at the state and local levels.

Key Developments to be Accomplished in SFY 04/05:

- ✓ Advance the opportunities for people with disabilities and their families to influence the full range of the system—from policy leadership to more discrete operations.
- ✓ Continue to advance the public policy relationship between the state and its local partners through the on-going work of the Public Partners Policy Group.
- ✓ Develop a cultural competency and awareness plan for the Division, LMEs, providers and partners.
- ✓ Publish State Plan 2005
- ✓ Develop new or modify existing rules and statutes that reflect mh/dd/sa reform.

Finance

Outcome:

To implement a financial strategy that advances the reformed service delivery system while fostering strong accountability.

Key Developments to be Accomplished in SFY 04/05:

- ✓ Finalize funding formula and plan for the service system.
- ✓ Finalize rates for services.
- ✓ Finalize and implement relevant components of the long-term finance strategy.

Programmatic Issues

Outcome:

To establish a service delivery system that is person-centered and family focused and promotes best practices.

Key Developments to be Accomplished in SFY 04/05:

- ✓ Provide technical assistance around natural and community supports for non-target individuals.
- ✓ Support and serve the target populations and continue to evaluate the target populations to determine necessary adjustments.
- ✓ Distribute approved service definitions with accompanying provider qualifications and utilization management guidelines.
- ✓ Develop plan for systems to transition to new support and service expectations.
- ✓ Initiate transition to new service expectations.
- ✓ Complete Comprehensive Prevention Plan.
- ✓ Continue implementation of the Child Mental Health Plan.
- ✓ Continue quality improvement efforts to assure model fidelity of supports and services.
- ✓ Continue research, dissemination and implementation of new best practices.
- ✓ Provide training for the LME in how the funding plan will be implemented.
- ✓ Continue technical assistance in building community capacity for service and service divestiture.
- ✓ Provide training for LME staff in customer service and rights protection.
- ✓ Continue technical assistance and consultation regarding the functions of the LME's.
- ✓ Provide technical assistance for local programs to increase consumer and family participation.
- ✓ Oversee implementation of the Piedmont Project.
- ✓ Implement new CAP-MR/DD waiver.
- ✓ Implement traumatic brain injury waiver.
- ✓ Develop best practice for self-directed services.
- ✓ Implement the Division's Workforce Development Plan.
- ✓ Continue development of the area program/county program consolidation plan.
- ✓ Refine the requirements and timeline for accreditation for LMEs.
- ✓ Refine the requirements and timeline for accreditation for providers.
- ✓ Coordinate hospital downsizing.
- ✓ Coordinate state development centers downsizing.
- ✓ Establish uniform and consistent operational policies and practices for all state facilities.
- ✓ Develop provider and LME report cards.

✓ Develop and implement a plan for expanding community education regarding reform.

Administration and Contracts

Outcome:

To establish the administrative functions required to implement the management, financial and programmatic systems.

Key Developments to be Accomplished in SFY 04/05:

- ✓ Perform modifications to management information systems
- ✓ Work with Division of Medical Assistance to revise the State Medicaid Plan to advance reform.

How Key Developments will be Accomplished

Management and Leadership

- ✓ **Advance the opportunities for people with disabilities and their families to influence the full range of the system—from policy leadership to more discrete operations.** The Department has established a state level Consumer and Family Advisory Committee (S-CFAC). The S-CFAC in conjunction with the Division's Executive Leadership Team (ELT) will provide input and conduct oversight of the Division's operations and efforts to accomplish the strategic outcomes of the State Plan. Participation at the state level ensures direct access to the ELT to bring forward the concerns and input of the local CFAC groups in their communities. The S-CFAC reports directly to the DHHS Secretary and will meet with the Secretary at least annually to provide a summary of the S-CFAC's perspective regarding Division efforts.

- ✓ **Continue to advance the public policy relationship between the state and its local partners through the on-going work of the Public Partners Policy Group.** The Division is dedicated to working with all of our public partners to ensure that reform is a success. In order to address issues related to reform that are of concern to the public partners of the mental health, developmental disabilities and substance abuse service system, a policy group has been formed – the Public Partners Policy Group. This group is comprised of representatives of the Department of Health and Human Services, area/county programs, county managers and county commissioners. The project director of the Legislative Oversight Committee facilitates the group's monthly meetings. Members are committed to addressing and resolving policy issues related to reform.

- ✓ **Develop a Cultural Competency and Awareness Plan for the Division of MH/DD/SAS, LMEs, providers and partners**. The Division recognizes the importance and has made a commitment to ensure that all components of the publicly funded system of mental health, developmental disabilities and substance abuse services are culturally and linguistically competent. During fiscal year 2004-2005 the Division will build on work begun in fiscal year 2004 under the leadership of Secretary Carmen Hooker Odom. The Division with the assistance of the Office of Minority Health sponsored a one-day cultural competency workshop. A professional and ethnic cross section of 100 citizen experts from across the state led by a nationally known consultant who specializes in cultural diversity issues met to develop practical guidance for the Division, the local management entities (LMEs) and their contract providers. This group of experts set the initial stage for the identification of stigmas to accessing and utilizing services as well as the cultural and linguistic barriers that prevent citizens from seeking services.

- ✓ **Publish State Plan 2005**. The secretary of the Department of Health and Human Services will submit to the Legislative Oversight Committee a State Plan for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services that clearly articulates the Division's strategy to accomplish mental health reform. The State Plan is a living document that is modified and revised as the Division implements strategies, analyzes data and receives feedback from our various stakeholders, CFAC members and citizens of the state. The Plan will be published and presented to the public on July 1, 2005.

- ✓ **Develop new or modify existing rules and statutes that reflect mh/dd/sa reform.** The Division will continue its assessment process to ensure that the rules and statutes impacting mh/dd/sa services support the new system design and are consistent with reform. The Division in partnership with its stakeholders will identify rules and statutes in need of amendment, addition and/or deletion and will propose draft language as necessary. A procedure for rule and statute change will be adopted to include a timeline with proposed effective dates.

Finance

- ✓ **Finalize funding formula and plan for the service system.**

- ✓ **Finalize rates for services.**

- ✓ **Finalize and implement relevant components of the long-term finance strategy.**

Programmatic Issues

- ✓ **Provide technical assistance around natural and community supports for non-target individuals.** The Division recognizes that some individuals, who have service and support needs, will not be part of the target populations. These consumers will be eligible for basic benefits such as assessment, outpatient treatment and crisis intervention that may be supported by state funding. The Division will work closely with local programs regarding the most equitable and effective ways in which to use state funding for service to these consumers. In addition, the public system must work to identify and develop appropriate natural and community supports. Actions at the local level to address the needs of non-target populations will require leadership and collaboration with consumers, families, advocates, community leaders, other agencies, providers, physicians and others who can help make services and community supports available to non-target populations. The Division will work cooperatively with the North Carolina Council for Community Programs to gather information and to provide technical assistance regarding the needs of non-target populations and ways in which those needs can be addressed.

- ✓ **Support and serve the target populations and continue to evaluate the target populations to determine necessary adjustments.** Providing services to individuals with the most severe disabilities is one of the foundations of mental health reform in North Carolina as described in chapter 1 of this Plan. Information about the number of people in the target populations who are served by the public mh/dd/sa system will be reviewed to assess the extent to which individuals in target populations are receiving services from the public system. The use and availability of specific evidence based, best practice services across the state will also be assessed. Data about the number individuals seeking services in the target and non-target populations will be reviewed to provide information about whether the current target population definitions are consistent with the goal of meeting the needs of individuals who are most seriously ill and disabled.

- ✓ **Distribute approved service definitions with accompanying provider qualifications and utilization management guidelines.** The divisions of MH/DD/SAS and Medical Assistance have worked together to develop several new and revised service definitions that are based on best practice and evidence based approaches to address the needs of consumers. These definitions specify the general provider qualifications and requirements as well as staff qualifications to provide the specific service. The definitions also outline the utilization criteria including entrance and continued stay criteria and provide information about the frequency or intensity of service that has been shown to lead to positive outcomes. In addition, the Division will complete a review of other state funded services to ensure that they are defined in a way that is consistent with the State Plan and best practice. **The Division will make approved service definitions and training opportunities available at least six months prior to their implementation date so that consumers, local programs and providers will be able to plan any needed transition and ensure that providers are prepared to deliver the services. As new or revised services are implemented, the Division will seek stakeholders' input regarding implementation issues and will review data regarding the use of the services.**

- ✓ **Develop plan for systems to transition to new support and service expectations.** The foundations of mental health reform include the following principles: person-centered planning, self-determination, emerging and best practice services and supports, consumer-driven services and supports, community collaboration and partnership and consumer participation in system design. The Division is committed to ensuring all partners and stakeholders receive adequate education and training specific to these basic principles. In order for mental health reform to be successful, all partners and stakeholders must be adequately informed of all related issues and policies. This will be accomplished through the development and implementation of the Division's Workforce Development Plan (communication bulletin #018). The Division has developed (with input from stakeholders) new service and support definitions that reflect evidence-based and best practice standards consistent with mental health reform. These definitions will replace the existing service definitions inclusive of state and Medicaid funding. Once approved, the new definitions will be available for individuals who meet specific criteria (as defined in the service definitions) and authorized by the LME. The Division's Best Practice Team will establish a workgroup comprised of LME staff, provider staff, consumers and Division staff to address transition issues and to develop a transition plan. The Division's Communications and Training Team will assist this workgroup with this deliverable.

- ✓ **Initiate transition to new service expectations**. A key to the transition to new service expectations is the clear delineation between the service delivery world of the area program and the systems management world of the LME. In FY 04-05, LMEs will move from being deliverers of services to managers and coordinators of services delivered primarily through contracted providers. In so doing, we will achieve the desired effect of eliminating or minimizing current conflicts of interest that exist when those roles are combined. In the management world, the LME is the designated leader, responsible for managing and implementing public policy within the local public system. The LME will retain the responsibility to ensure service quality and rights protection for people served in its qualified provider network. As the public policy manager, the LME is responsible for community based planning, organizing and managing policy in a manner that ensures both conservation of resources and maximizing funds directed toward supports, services and treatments that produce valued outcomes and effective performance. Closely related, the transition from current service definitions to the new service definitions (that will be submitted to CMS and that support the State Plan's emphasis on person-centered and family focused service provision) will be fundamental in the Division's efforts to support those best practices that are fundamental to reform.
    - **I**dentifying available local resources, both paid and volunteer, and bringing them into an integrated, user-friendly service system that meets the needs of people with disabilities throughout the catchment area and is consistent with state policy. Timeline: June 30, 2005 and FY 2005-06.
    - Focusing on the stewardship of limited resources by assuring that local systems serve people with the most severe disabilities and use best practice models that have been shown to result in positive outcomes for people. Timeline: June 30, 2005.
    - Supporting LMEs in implementing the service definitions as approved by CMMS in a timely and efficient manner. Timeline: October 1, 2004-June 30, 2005.

- Evaluating LME performance and the performance of the local system by studying system performance indicators and outcome measures and by consistent gains made through continuous quality improvement activities. Timeline: June 30, 2005.

✓ **Complete Comprehensive Prevention Plan.** A comprehensive prevention plan is being developed to provide best practice recommendations and an implementation framework for LMEs and CFACs. The plan will support the Prevention/Early Intervention Team mission and further articulate the State Plan's intent to intervene early and engage community prevention activities.

✓ **Continue implementation of the Child Mental Health Plan.** North Carolina will provide children and families with mental health needs a system of quality care that includes accessible, culturally appropriate, individualized mental health treatment, intervention and prevention services, delivered in the home and community in the least restrictive and most consistent manner possible.

✓ **Continue quality improvement efforts to assure model fidelity of supports and services.** Integral to the implementation of evidence-based practice (EBP) is the assurance of fidelity to the practice being implemented. In conjunction with the Best Practice Innovations Team, the Justice Systems Innovations Team, and the Prevention and Early Intervention Team, the Quality Management Team will research appropriate fidelity scales for evidence-practices that are being implemented as part of reform and these scales will be evaluated for adoption. These fidelity scales are designed to sample the critical ingredients that are imperative to the successful implementation of an evidence-based practice. Systems and protocols will be developed to administer these fidelity scales in a manner that is independent, accurate and feasible.

✓ **Continue research, dissemination and implementation of new best practices.** Implementing best practices is fundamental to the Division's reorganization. Best practices are a result of national clinical research and application, evidenced by positive outcomes. Services that result in desired life outcomes for individuals in an efficient and consistent manner are the best use of existing resources and increase the availability of services and supports. The Division will work to:

- Develop and sustain community involvement in and commitment to practice improvement in the delivery of services.
- Improve the quality of treatment, services and supports through the adoption of evidence based practices in community based provider organizations.
- Identify successful methods and models for implementing evidence-based practices in community based provider organizations.
- Identify and address training needs related to evidence based practices.
- Facilitate the establishment of a sustainable, statewide best practice management coordination structure that is external to the Division.

✓ **Provide training for LMEs in how the funding plan will be implemented.**

- ✓ **Continue technical assistance in building community capacity for service and service divestiture.** The Division continues to provide guidance and technical assistance in the functions needed to build community capacity and service divestiture. Targeting services for divestiture, assessing the community and establishing leadership in community collaboration are important functions of the LME. These activities should include consumer participation in the development of a provider network and in the identification of informal resources that will meet the needs of the consumer and the community. Marketing techniques designed to reach both the community and potential providers will need to be developed and implemented. These LME functions should be developed and implemented to better serve the consumers living in the community of their choice. Annual assessments by the Division will help aide in the identification of areas needing services. The Division's teams are available to assist by helping coordinate the development of a strategic plan that incorporates the functions needed to divest of services and build community service capacity.

- ✓ **Provide training for LME staff in customer service and rights protection.** Ensuring rights protection and providing a vehicle to address consumer and family member concerns is a vital part of reform. The new administrative rules to implement SB 163 specify responsibilities for providers, LMEs and the Division in documenting, reporting and analyzing consumer health and safety incidents while in MH/DD/SA services. A stakeholder work group will continue to monitor the incident reporting requirements. The Division and the North Carolina Council of Community Programs plan training sessions to develop customer services offices in the LMEs and in the provider network. The goal of these endeavors is to create timely responses to all concerns in order to protect rights and to improve confidence in the system.

- ✓ **Continue technical assistance and consultation regarding the functions of LMEs.** For FY 2004-2005 the major functions of LMEs are expected to include the following for which the Division's LME Team in conjunction with other Division teams will continue to provide technical assistance and consultation to LME. The North Carolina Council of Community Programs is also a major contributing partner in supporting area programs / LMEs by providing training and education as a form of technical assistance to support area programs in the reform process.

- ✓ **Provide technical assistance for local programs to increase consumer and family participation.** Division staff are located strategically across the state to provide technical assistance to their assigned consumer and family advisory committees (CFACs), community collaboratives and grassroots efforts. Staff participate in training for county commissioners to encourage greater awareness of the purpose and value of involving consumers and family members in their local mental health service delivery system. In addition, staff train community organizations interested in involving consumers and family members in their community mental health services.

- ✓ **Oversee implementation of the Piedmont Project.** In response to the state's reform efforts, Piedmont Behavioral HealthCare, an area authority serving five counties, has put forth a business plan with the LME functioning as a prepaid health plan. Over time, the Piedmont LME will transition all services currently provided through the area authority to the private sector. As a prepaid health plan, the LME would recruit providers, develop and oversee a comprehensive mh/dd/sas provider network that would assure access to care

for all enrollees. The LME would be responsible for authorizing payment for services, processing, paying claims and conducting utilization and quality management functions. Piedmont's goal is to transform the local mh/dd/sa system of services from a supply driven model to a system driven by consumer and family priorities to a system that is capable of making continual adjustments to meet the changing needs and choices of persons with behavioral health and developmental disabilities needs.

- ✓ **Implement a new CAP-MR/DD waiver.** This waiver provides home and community based services to targeted individuals who, but for the provision of such services, would require ICF-MR level of care. Also, waiver services are targeted to serve new persons each waiver year and to impact de-institutionalization of persons residing in public or private ICF-MR facilities. Review of our current CA-MR/DD waiver reveals that our current home and community based waiver requires changes to be in line with state Reform efforts.

- ✓ **Implement traumatic brain injury waiver.** A committee with representatives from the Division and the Division of Medical Assistance will develop a traumatic brain injury waiver. Once the waiver has been developed and approved, it will be implemented by the staff of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

- ✓ **Develop best practice for self-directed services.** The Division will develop structures that make it possible for individuals with disabilities to choose self-directed options for the delivery of services. Self-directed services are those in which the consumer has maximum choice and control over services and supports; decides which services to use within a budget; and chooses to select, supervise and dismiss staff. Structures that support self-directed supports have the following components:
    - Person-centered plans developed with the direction of the person and including flexible options for meeting needs.
    - Established individual budgets within which the person can choose the services and supports to buy.
    - Assistance in arranging for and coordinating services and supports so that needs are met.
    - Assistance in carrying out duties as an employer, including hiring, supervising and paying staff; filing taxes; and performing related financial functions.
    - Assuring the safety and quality of services to individuals who are self-directing, including back-up staffing plans and monitoring individual budgets.

- ✓ **Implement the Division's Workforce Development Plan.** The DMH/DD/SAS Workforce Development Plan is designed to address complex issues in an evolving system of care. In order to meet the objectives of reform, the Plan will include: developing a learning portal, publishing an annual plan, sponsoring training contracts with other organizations, contracting for a curriculum on person-centered planning, developing a plan to increase cultural competence, supporting state-wide conferences and certifying instructors in NC Interventions. The Division recognizes that staff are its most important asset and will invest in training that prepares the workforce to handle the sweeping changes of reform.

- ✓ **Continue development of the area program/county program consolidation plan.** The LME team has completed an area program/county program consolidation outline plan that has been submitted for review. The goal for area programs to consider consolidation was to reach the optimal and efficiency of effectiveness as a LME with a minimum population base of 200,000 or five to six counties in an LME group. Below is a list of mergers and consolidations that are successfully completed as a part of mental health reform.

Mergers / consolidations completed	Effective Date
Piedmont: merger of Piedmont with Davidson County	January 2004
Western Highlands: merger of Blue Ridge, Trend and Rutherford-Polk	January 2004
Sandhills: merger of Sandhills with Randolph County	July 2003
Eastpointe: merger of Duplin-Sampson, Lenoir and Wayne	July 2003

- ✓ **Refine the requirements and timeline for accreditation for LMEs.** In a system of reform, with area authorities becoming LMEs, the accreditation required needs to reflect the primary requirements of the management entity in authorization of services, utilization review and management and quality assurance and quality improvement. The Division will continue to identify appropriate national accrediting bodies and consider practical timelines for the requirement that all LME's become accredited by one of these identified accrediting agencies.

- ✓ **Refine the requirements and timeline for accreditation for providers.** The Division has expressed the importance of a commitment to quality and meeting identified outcomes in the provision of mh/dd/sa services. In service to that commitment, the Division continues to study the advisability of encouraging national accreditation by providers of mh/dd/sa services. In SFY 2004-2005 as a function of implementing the State Plan, the Division will decide whether accreditation will be required or encouraged (but not required) for mh/dd/sa providers. If it is required, the Division will decide if that requirement applies to all providers of services, and if so, if there should be a phased timeline or a single one for that accreditation to be accomplished. Whatever the decisions are, they will apply both to private providers and LMEs who continue to provide services until they have divested of those services.

- ✓ **Coordinate hospital downsizing.** The process established in SFY2003 and followed in SFY2004 to support downsizing of geriatric and adult long-term beds in the state's psychiatric hospitals will be used again in SFY2005. This process starts with regional planning meetings with LMEs to identify and plan for the array of community-based services to support reduction in hospital beds. Meetings will be held in the first and second quarters of SFY2005. By the end of the second quarter, each LME will submit to the Division a capacity expansion plan to meet the needs of individuals who will be discharged from beds and/or would have been served by beds to be closed. Upon approval of the community capacity expansion plans, the Division will issue allocations from the Mental Health Trust Fund starting in the third quarter to support start-up activities as identified in the LME plans. With successful implementation of start-up plans and placement of individuals in the community as necessary and appropriate, targeted beds

will be closed at the end of SFY2005. Savings generated from closed hospital beds will be allocated to provide recurring funding for expanded community services, beginning in first quarter SFY2006. State hospital downsizing goals for SFY2005 consist of a total of 113 beds, including 18 adult admission beds each at Broughton and Dorothea Dix Hospitals, 16 nursing and 31 adult long-term beds at Cherry Hospital and 30 adult long-term beds at John Umstead Hospital. In addition, targeted beds from SFY2004 not closed by June 30, 2004 will be closed in SFY2005 when community capacity developments support such closure. Target dates for closure of identified child and adolescent beds, including Psychiatric Residential Treatment Facility (PRTFs), will be established through implementation of the Child Mental Health Plan.

- ✓ **Coordinate state developmental centers downsizing.** Ongoing efforts to coordinate downsizing of the state developmental centers (SDCs) requires Division staff to work with all of the communities represented through the LMEs, various advocate and provider groups and other teams within the Division. At the core of the premise for downsizing are the requirements that: (1) persons must move from the SDCs in larger numbers to allow the facilities to close residential units, thereby reducing operating expenses; and (2) communities must develop capacity to serve the complex and challenging array of services and intensity of consumer needs sufficient to reduce and/or eliminate requests for SDC admissions.

- ✓ **Establish uniform and consistent operational policies and practices for all state facilities.** The Division through the State Operated Services section will establish uniform and consistent operational policies and practices for all state facilities. These policies and practices will ensure that the delivery of services in the facilities operated by the state utilize best practices and advance the objectives of reform.

- ✓ **Develop provider and LME report cards.** Integral to mental health reform are efforts to build enhanced choice, access and accountability to consumers and families, and to assure systems performance responsiveness at every level, including providers, LMEs and state and federal administrators and policy makers. The Quality Management Team will coordinate the development of recommendations for a local provider quality report card and for an LME quality management report. This quality report will be designed to provide comparative information on standardized measures of access, quality and effectiveness of services and supports.

- ✓ **Develop and implement a plan for expanding community education regarding reform.** Leadership of the Division recognize the importance of accurate and timely communication with stakeholders regarding matters related to reform. Staff of the Division with the assistance of the DHHS Office of Public Affairs will develop and implement a plan to educate the public on issues related to reform. The plan will outline the effective use of all media outlets to get the message out about reform, dispel incorrect information that has been circulated and identify those public and private partnerships that can assists in these efforts.

Administration and Contracts

- ✓ **Perform modifications to management information systems.** The status of the information systems within the Division in the early part of 2000 were fragmented and isolated. Updates to any of the systems were generally done by manual means. There was very little interconnection. To produce reports it was necessary to compile information from several systems requiring different people from different sections to cooperate and understand the requested needs. Implementation of mental health reform requires that the Division have access to the most accurate and relevant information possible and presented in a user accessible manner. The goal of the Information System Services Team is to integrate and automate the various information systems into a definable single-source decision support platform. All system modifications and replacements will be directed to the development of the most "state of the art information and decision support systems" possible using the concepts of enterprise systems and standards across all business functions.

- ✓ **Work with Division of Medical Assistance to revise the State Medicaid Plan to advance reform.** The leadership of the two divisions has been working on a variety of issues related to reform of our public mental health, developmental disabilities and substance abuse services system. Many key issues are under development and consideration. Once these issues are finalized, necessary revisions to the State Medicaid Plan will be made to advance reform.